Appendix A

SAMPLE IHP

Name _____ Date _____

Phone numbers
Parent/guardian#1 _____
Work_____
Home_____
Parent/guardian#2 _____
Work_____
Home_____
Other emergency contact_____
_____
Doctor _____
_____

Blood glucose
Usual times to test glucose at school _____
Extra tests (check those that apply) _____ before exercise
_____ after exercise
_____other (explain)
_____
Can child perform own test? Yes No Adult supervision needed? Yes No

Hypoglycemia
Usual symptoms _____
What glucose level mandates treatment if no symptoms _____
Treatment _____
_____
Glucagon (dose) _____
Any activity restriction_____

Hyperglycemia
Usual symptoms _____
Usual blood glucose to test for ketones _____
Treatment _____
_____
_____
Any activity restriction _____

Insulin
Time _____ Dose _____ by syringe, pen, pump (choose)
_____
Can student give own injections? Yes No (All insulin injections should be supervised by the school nurse).

Meals and snacks
Times in school _____ _____
_____ _____

Circumstances requiring parent notification _____

_____

_____

_____

Distribution A. Received entire IHP

B. Received Specific Directions for Hyperglycemia and Hypoglycemia

Name/Position A/B Date

_____

_____

Additional necessary accommodations (e.g. class trips, testing, bus)_____

_____

_____

___

Emergency Health-Care Plan _____

_____

_____

_____

Signatures School nurse _____

Parent/guardian_____

Health-care team representative_____

Appendix B

PARENT/GUARDIAN PERMISSION TO RELEASE AND
EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information to occur between the School Health Services Nursing Staff and:

NAME: _____ PHONE: _____

ADDRESS: _____

Regarding: ___ any or all information
___ specific information regarding _____
contained in the record of:

_____ _____
name date of birth

_____
school

This authorization is in effect for one calendar year from today: _____
Date

Signature of parent/guardian: _____

Appendix C

DIABETES SUPPLIES

Parents are responsible for providing all diabetes supplies. The following is a list of typical supplies:

INSULIN SUPPLIES
Insulin bottle(s)
Insulin syringes
Alcohol wipes/antiseptic wipes (optional)
Or
Insulin pen(s) with cartridge loaded
Pen needles
Alcohol wipes (optional)

Pump supplies, if needed

BLOOD SUGAR TESTING SUPPLIES
Blood glucose meter and manufacturer's instructions
Test strips (with code information, if needed)
Finger poking device
Lancets
Cotton balls (if needed)
Logbook to record blood sugar and amounts of insulin

FOOD SUPPLIES
Snack foods
Low blood sugar (hypoglycemia) supplies; glucose tablets, juice and carbohydrate/protein snack

OTHER Urine ketone test strips

Appendix D

SAMPLE DIABETES CHECK LIST FOR SCHOOL NURSES

Student:_____School:_____
Birthdate:_____Grade:_____
Physician:_____Home
Phone:_____

(Dates)

_____ 1. School nurse is notified that student with diabetes will be attending school.

_____ 2. Call or arrange a meeting with parent(s)/guardian and student, if appropriate.

___ a. Discuss parent/student expectations of diabetes care while at school.

___ b. Discuss details of diabetes management plan and potential accommodations.

___ c. Determine the equipment and supplies needed for school and obtain prior to student admittance

___ d. Discuss plans for communication with parent and health-care team

___ e. Request that parent sign an exchange of medical information form and release of confidential medical information form

_____ 3. Meeting with parents, school nurse and other members of the school staff.

Typical accommodations issues:

___ a. Management of low blood sugar

1. Who?
2. Where?
3. When?
4. When and how to communicate to parents?
5. Restriction of activity?

___ b. Management of high blood sugar

1. Who?
2. When?
3. How?
4. When and how to communicate to parents?
5. Restriction of activity?

___ c. Blood testing

1. Who?
2. Where?
3. When?

4. What to do with results?
5. When and how to communicate to parents?

___ d. Insulin injections
1. Who?
2. Where?
3. When?
4. When and how to communicate to parent?

___ e. Meals (and snacks)
1. Who?
2. What's too much or too little monitoring?
3. When and who to notify?
4. Where (location)?
5. Replacement?
6. Special occasions (parties, field trips).

___ f. Bathroom privileges

___ g. Access to drinking water

___ h. Transportation
1. Who?
2. What route?
3. When?

___ i. After-school activities
1. When?
2. Where?
3. Orders?

___ j. Identify and obtain legal documents for consent and authorization of treatment and exchange of information.

_____ 4. Review school-day schedule and assess level of independence.
_____ 5. Identify potential issues requiring accommodations.
_____ 6. Clarify specifics of treatments using Health-Care Team Orders.
_____ 7. Determine which staff will be educated and arrange for same.
_____ 8. Notify and educate all personnel working with student. Have all pertinent individuals sign the IHP. Note the distribution.
_____ 9. Provide classroom education if requested by parent or child.
_____ 10. Review annually IHP and/or revise as needed.
_____ 11. Adhere to the school district's bloodborne pathogen standard during blood testing.

Appendix E

SUGGESTED HEALTH-CARE PROVIDER ORDERS

Student's Name_____ Grade_____ School Year_____ Date_____

TASK	ACTION(S)
Blood Glucose Testing	____for signs/symptoms of low blood sugar
	____for signs/symptoms of high blood sugar
	____times/week before lunch (specify days) Mon Tues Wed Thurs Fri
	____other (specify)_____
	____not applicable
	____notify parents immediately for blood sugar<____mg/dl and/or >____mg/dl
	____notify parents (specify) daily/weekly/monthly of any results done at school
Urine Ketone Testing	____for blood sugar >____mg/dl
	____for acute illness, i.e. vomiting, fever, etc.
	____student must have unlimited access to restroom and drinking fountain/water bottle
	____notify parents immediately for _____ ketones (NOTE: if parents cannot be reached and the student has _____ ketones and is vomiting, contact paramedics for transport to E.R.)
	____notify parents (specify) daily/weekly/monthly of any results done at school
	____other (specify)_____
	____not applicable
	____restrict gym/sports/etc. for _____ ketones
Meal Planning	____mid-morning snack at _____a.m.
	____mid-afternoon snack at _____p.m.
	____other (specify)_____
	____snacks should be taken (specify): ___Classroom ___Nurse's Office ___Other_____
Activity	____no restrictions
	____restrict gym/sports/etc. for _____ketones
	____Medical ID must be worn at all times including during gym/sports/etc.
	____may attend class trips/field trips/etc.
	____other (specify)_____

SAMPLE HEALTH CARE PROVIDER ORDERS (Page 2)

Student s Name_____ Grade_____ School Year_____
Date_____

TASK	ACTION(S)
INSULIN	____Administer ____ units of _____ insulin subcutaneously for blood sugar > ____ mg/dl. ____Above dose may be repeated every ____ hours. ____Students with insulin infusion pumps shall be permitted to wear and attend to the pump. ____not applicable. ____other (specify)_____.
	NOTE: all doses must be supervised or administered by school nurse.
Hypoglycemia/Glucagon	____Treat all blood sugar <____mg/dl with ____grams of rapid-acting carbohydrate followed by meal/snack. ____For severe hypoglycemia (or suspected severe hypoglycemia) when the student is unconscious or unable to swallow, give ____mg Glucagon I.M. or S.Q. AND ____contact parents ____contact paramedics immediately. ____other (specify)_____.
Absences	____for diabetes visits approximately every ____ months. ____other (specify)_____.

Name (Please Print) _____ **Doctor's Stamp_____**
Phone Number_____

Signature_____